

- ☐ Initiate Waiver services
- ☐ Service Modification
  - ☐ Add a service
  - ☐ Increasing amount of service
  - ☐ Decreasing of service
- ☐ Provider Modification (requires 2 ISARs)
- ☐ End a service

## MR/ID Waiver Assistive Technology Individual Service Authorization Request

CSB \_\_\_\_\_

CSB provider # \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider E-mail Address: \_\_\_\_\_ Provider Number: \_\_\_\_\_

(if Medicaid Provider number is assigned)

Name: _____	Start: _____	End: _____
Last,                      First                      MI	Date	Date

Medicaid Number: \_\_\_\_\_

The individual must have at least one other MR/ID Waiver service to receive this service.

**CHECK SERVICE TO BE PROVIDED**

**COST**

**ODS USE ONLY**

<input type="checkbox"/> T1999 Assistive Technology only		
<input type="checkbox"/> T1999 U5 Assistive Technology; Maintenance costs only		

Maximum Expenses for MR/ID Waiver = \$5,000 per  
**calendar year**

Note previous expenses this  
calendar year: \_\_\_\_\_

**Reason for this request (attach documentation of recommendation by a qualified professional)**

Documentation in the record that item/s requested are not covered by State Plan and not available from a DME provider.

☐ Yes    ☐ No    Explain as applicable: \_\_\_\_\_

Check the following as needed by the individual:

- ☐ Specialized medical equipment and ancillary equipment/supplies necessary for life support
- ☐ Durable/non-durable medical equipment and supplies
- ☐ Adaptive devices, appliances, and/or controls which enable an individual to be more independent in activities of daily living
- ☐ Equipment and devices which enable an individual to communicate more effectively

Describe the specific modifications, equipment, supplies and/or other services to be provided:

Comments: \_\_\_\_\_

*I agree that the above plan for supports is appropriate to the identified needs of this individual. This PFS has been approved by the individual and included in the ISP maintained in the Support Coordinator's/Case Manager's record.*

CSB Rep/Supp. Coord./Case Mgr.  
(print)

Signature

Phone No.

Fax No.

Date